

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP   ( ) IE   ( ) IC	<b>Response Timely Filed?</b> (x) Yes   ( ) No
Requestor's Name and Address Houston Community Hospital P O Box 11586 Houston, Texas 77293	MDR Tracking No.:                      M4-04-3831-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Interstate Insurance Company 2301 Highway 190 W Deridder, Louisiana 70634-6004 Box 01	Date of Injury:
	Employer's Name:                      David Hatton Logging, Inc.
	Insurance Carrier's No.:              91TX1918

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/15/03	07/21/03	Hospital Admission	\$38,812.00	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

"This disputed claim would fall under TWCC Rule 134.401, Stop-Loss Reimbursement Factor, since this claim exceeds \$40,000.00. Provider is requesting this claim be paid per the Stop-Loss Reimbursement Factor."

## PART IV: RESPONDENT'S POSITION SUMMARY

"The bill for Provider's Hospital did meet the minimum dollar amount required to be considered for stop-loss reimbursement, however, they have failed to provide any documentation of unusually costly or extensive services during the patient's stay. The only medical records submitted were an anesthesia report, and an operative report which clearly states that there were no complications during the surgery."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem methodology described in the same rule. The operative report indicates that this was an irrigation and debridement of left flank wound. The operative report also indicates the patient was taken to recovery in stable condition and no complications were noted in the operative report.

The carrier made reimbursement for the 6-day stay in the amount of \$6,708.02. Based on a per diem reimbursement (6 day-stay x \$1,118.00 = \$6,708.00) the carrier's reimbursement covers the per diem rate.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is not entitled to additional reimbursement.

**PART VI: COMMISSION DECISION**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

Michael Bucklin

07/12/05

Authorized Signature

Typed Name

Date of Order

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787 Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_